

August 3, 2000

ENHANCED HEALTH CARE RESOURCES SHARING AUTHORITY - SELLING

1. PURPOSE: This Veterans Health Administration (VHA) Directive further implements provisions of Public Law (Pub. L.) 104-262, "The Veterans Health Care Eligibility Reform Act of 1996," which significantly expands the Department of Veterans Affairs (VA) health care resources sharing authority in Title 38 United States Code (U.S.C.) Sections 8151 through 8153.

2. SUMMARY OF CHANGES: Expansion of Pub. L. 104-62 and VA health care resource sharing authority requires definition of new guidelines. Veterans Integrated Service Network (VISN) and medical center Directors are responsible for compliance with the requirements outlined in this Directive, for meeting all requirements of law and policy, for meeting all labor management responsibilities, for the establishment of appropriate and legally sound contract terms, for making sound business decisions, for ensuring that staff are properly trained and are fully capable of exercising any delegated authority, for ensuring adequate documentation of the contracting process, and for contract and performance monitoring.

3. RELATED ISSUES: VHA Handbook 1660.1.

4. RESPONSIBLE OFFICE: The VHA Chief Financial Officer (17) is responsible for the contents of this Directive.

5. RESCISSIONS: M 1, Part 1, Chapter 34, Section II, is rescinded.

6. RECERTIFICATION: This document is scheduled for recertification on or before the last working day of August 2005.

S/ Melinda L. Murphy for
Thomas L. Garthwaite, M.D.
Acting Under Secretary for Health

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2. BACKGROUND

a. Section 301 of Pub. L. 104-262, dated October 9, 1996, contains provisions which eliminate barriers and disincentives to the sharing of health care resources with non-VA entities. VHA Directive 97-015, dated March 12, 1997, contains information on the types of resources that can be shared, and who qualifies as a sharing partner under the expanded authority, but addresses issues primarily related to VA’s acquisition of health care resources. This Directive deals primarily with issues related to VA’s selling of health care resources.

b. VHA may enter into sharing agreements or contracts for the sale of VHA health care resources with any health care provider, or other entity, group of individuals, corporation, association, partnership, Federal, State or local governments, or individual. For this purpose, a health care provider is defined as including health care plans and insurers, and any organizations, institutions, or other entities or individuals who furnish health care. VHA may not enter into any sharing contracts with prohibited foreign entities (e.g., Cuba, Iran) or with partisan political entities.

c. VHA may enter into sharing agreements or contracts for the sale of health care resources, including hospital and ambulatory care, mental health services, medical and surgical services, examinations, treatment, rehabilitative services and appliances, preventive health care, prosthetics, and other health care services. Services may be offered to a sharing partner for non-veterans only if the service is within the scope of VA’s authority and is authorized by law for veterans.

d. The term “health care resources” also includes health care support and administrative resources, the use of medical equipment, or the use of space. Health care support and administrative resources include those services, apart from direct patient care, determined necessary for the operation of VA facilities. (Examples of services provided by VA that are not needed for the operation of VA facilities include child care, fitness centers, and job placement services for displaced workers. These kinds of services may not be included in sharing contracts.) Health care support resources serve medically related purposes (e.g., biomedical equipment repair, patient transport). Administrative resources include services not unique to the provision of medical care, but deemed necessary to support the operation of a medical center (e.g., transcription services, grounds maintenance).

3. POLICY

a. Contracts to Sell Health Care Resources

(1) Contracts to sell health care resources may be executed only if a specific determination is made:

(a) That veterans will receive priority for services under such an agreement (e.g., no contract will result in the diminution of existing levels of services to veterans); and

(b) That the agreement is necessary either to maintain an acceptable level and quality of service to veterans, or will result in improvement of services to veterans.

(2) The contract file must include a certification from the Veterans Integrated Service Network (VISN) Director, or the medical center Director, that the preceding conditions have been met. A copy of this certification must be submitted electronically, along with a copy of the executed contract, to the Office of Finance Sharing and Purchasing Office (SPO) (175), VHA Headquarters, within 5 work days of the contract award.

(3) All concept proposals to sell VA resources under this authority must be approved by the Rapid Response Team (RRT), consisting of staff from the SPO, Office of General Counsel (025) and Acquisitions and Material Management (095). The concept proposal must be e-mailed over Microsoft Exchange to the SPO and is to be approved by the VISN and/or medical center Director, or their designees.

(a) The concept proposal should include the following:

1. The resource to be sold;
2. Name of the sharing partner;
3. The term of the agreement; and
4. The costing methodology or basis of rate reimbursement.

(b) The SPO will e-mail the results of the RRT review to the facility submitting the contract for review and this response shall be part of the contract file. **NOTE:** *Concept approval by the RRT is not a legal or technical review nor approval of the sharing agreement; field facilities will be notified when concept approval for a specific resource is no longer needed.*

(4) Contracts valued at \$500,000 or more may be executed only after legal and technical review by VA Central Office (legal review will be conducted by General Counsel, VA Central Office). Local officials are responsible for incorporating any changes required by the legal and/or technical review before the contract is executed. Contracts requiring legal and technical review should be sent to the Sharing and Purchasing Office over Microsoft Exchange or mailed on a computer disk to VA Central Office. That office (175) is responsible for coordinating the

review and communicating the results to the facility submitting the contract for review. Following legal and technical review, an appropriately designated VA selling official may execute the contract.

(5) General Counsel field attorneys must have a final review of all contracts with a total value less than \$500,000 before they are executed. Approval authority for all contracts to sell services having a total value of less than \$500,000 over the period covered by the contract (initial year plus any option years) is delegated to the field.

(6) Proposals to sell inpatient services to non-veterans require the approval the Secretary of Veterans Affairs and the Under Secretary for Health. These proposals might also require presentations to representatives of national veteran service organizations and congressional delegations. The SPO will coordinate these presentations and provide technical assistance on the information required.

b. **Enhanced Sharing Agreements for the Use of VA Space.** Enhanced sharing agreements for the use of VA space (including parking, outdoor recreational facilities, and vacant land) are authorized under 38 U.S.C. Section 8153.

(1) In sharing the use of VA space under this authority, VA must consider the use to which the space would be put by the potential partner to the contract. Potentially controversial uses are to be avoided. For example, VA facilities should not sell use of space for any illegal activity, abortion services, the sale of alcohol or firearms, gambling activities, partisan political activities, correctional-system activity, storage or processing of hazardous materials, billboards, or purposes which would violate community standards. VA facility managers should also consider impacts on patient privacy, VA computer systems, telecommunications and data, parking, and fire, health, and safety, and security and law enforcement issues in sharing the use of VA space.

(2) Sharing partners may use their own resources to make capital improvements to existing VA space. However, VA must approve the proposed capital improvements in advance and must ensure that the project is an overall “good business” decision for VA. VA must require that the sharing partner comply with the minimum wage requirements of the Davis-Bacon Act (40 U.S.C. Section 276a) when renovating or improving VA space, even though Federal appropriated dollars will not be directly expended on the construction project.

(3) VA may use medical care appropriation funds under the non-recurring maintenance (NRM) program to make improvements to VA space for use by a sharing partner. Neither major nor minor construction funds may be used to improve space solely for the purpose of use by a sharing partner.

(4) All proceeds from contracts for the use of VA space under the enhanced sharing authority will be deposited into the medical care appropriation account at the VA facility.

(5) It may be appropriate, as sound business practice, for VA to pay damages to a sharing partner in the event that VA must terminate a use of space contract before the time specified for the contract, particularly if the sharing partner has made a significant capital investment in the

space, but only if provisions for damages are included in the terms of the initial contract. Such contracts cannot provide for unlimited liability or indemnification. The following provisions must be included in any sharing contract involving liability payments from VA: first, set a dollar limit on the amount of damages that the facility will pay in each year if the agreement is terminated; second, limit VA's liability to the amount of appropriated funds available to the facility at the time payment is made; and third, state that VA does not promise that Congress will appropriate additional funds to meet any deficiency in the event that damages must be paid. In the event that damages are to be paid in accordance with the terms of a contract, the medical center will be responsible for the payment of the damages from the Medical Care Account.

(6) Contracts for use of VA space by a sharing partner to provide inpatient hospital care to their own patients may be developed under this authority, if the space in question is discrete from VA inpatient beds, the space is staffed by the sharing partner's physicians and nurses, and the partner operates their own admission and discharge system. VA may provide support services, such as housekeeping, food service, or lab and x-ray services to the sharing partner using such space. Contracts of this nature are considered to be use of space, equipment and support services contracts and not contracts for VA to provide inpatient care. Under no circumstances may a sharing partner sub-let use of VA space obtained through an enhanced sharing contract to a third party without prior approval from the Rapid Response Team, VA Central Office.

(7) Use of space sharing agreements for up to 20 years total may be executed under this authority. The Under Secretary for Health may grant an exception to the 20-year term limit. The VA Central Office RRT must approve the concept for proposed use of space agreements totaling 10 to 20 years. A detailed cost-benefit analysis, market survey results, and a statement of how revenue generated will be used shall be submitted with these requests. Proposals involving new construction and not just renovation of existing space, shall be submitted under the Enhanced-Use Lease Program and not under sharing.

(8) A use of space agreement for ten years or longer requires an early termination clause.

(9) Use of space proposals that exceed \$600,000 annually, \$4 million over term, or \$4 million in investment are subject to the VA Capital Investment Process and review by the VA Capital Investment Board.

c. **Contracts for Use of VA Equipment.** Contracts for use of VA equipment may be executed under the enhanced sharing authority. Appropriate terms should be included in the contract, addressing responsibility for equipment maintenance or loss. The sale, resale, or other disposition of VA or Government property or equipment (such as new or used computers or torn linens) is not authorized under enhanced sharing. Disposition of Government property is governed by Federal Property Management Regulation Title 41 Code of Federal Regulations (CFR) 101 or Federal Management Regulations 41 CFR Parts 102-1 through 102-22. Contracts for the use of equipment may be executed for up to five years or for the useful life of the equipment, whichever is longer.

d. **Contracts for the Sale of VA Direct Patient Care Services.** Contracts for the sale of VA direct patient care services (inpatient or outpatient care) may be executed under the enhanced

sharing authority. However, without the express permission of the Under Secretary for Health and of the Secretary of Veterans Affairs, no contracts for the sale of VA inpatient services for non-veterans will be considered or executed under the health care resources sharing authority.

NOTE. *TRICARE agreements are VA-Department of Defense (DOD) sharing agreements under 38 U.S.C. Section 8111 and are encouraged.*

(1) VA facilities seeking to sell services to non-VA health care facilities under enhanced sharing contracts may obtain State permits and licenses where State law requires those non-VA health care facilities to purchase services from entities permitted and/or licensed by the State. VA facilities may pay applicable service charges and fees in obtaining these permits and/or licenses.

(2) VA facilities may enter into contracts with Health Maintenance Organizations (HMOs), other types of managed care organizations, or other types of health care providers to sell hospital and outpatient care. If a veteran is enrolled with VA and elects to receive care from VA as a veteran, that individual must be treated as a veteran regardless of membership in an HMO. The treatment of such a patient would be subject to VA protocols, not the protocols of the HMO. The veteran also would be required to pay VA any co-payments imposed by VA. Alternatively, the veteran could elect to receive hospital or outpatient care from VA as a member of the HMO that has contracted with VA. Any care for non-service connected conditions furnished to individuals as veterans must be billed under the Medical Care Cost Recovery (MCCR) Program. If the veteran elects to receive care pursuant to the HMO contract as an HMO member, VA co-payments would not apply, but the individual would be subject to any co-payments the HMO might impose. Finally, if the veteran is not enrolled with VA, the veteran must be treated as an HMO patient pursuant to the terms and conditions of VA's sharing agreement with the HMO, unless an exception listed in 38 CFR Section 17.37 applies. The groups of veterans listed in 38 CFR Section 17.37 need not be enrolled with VA for some or all VA care. To the extent that a veteran is being treated "as a member" of an HMO pursuant to a sharing contract, and not "as a veteran," VA must bill the HMO. **NOTE:** *Contracts must require payment to VA from the HMO of the full contract amount for services furnished and may not require VA to coordinate insurance benefits or to pursue third party insurance billings and collections for care furnished to non-veterans.* An appropriate Release of Medical Information form must be signed by the patient before information from VA medical records is released to the referring HMO. The provision in subparagraph 4a.(1) that "veterans receive priority for services under such an agreement" does not require that facility to give preferential treatment to persons receiving care as a member of an HMO or other health care plan with whom VA has a contract to provide services if those persons happen to be veterans. The person may choose to be treated as a veteran or as a member of the health care plan. The choice made by the veteran will determine the amount of any required co-payments and the extent of hospital care or outpatient care available.

(3) Contracts may be executed for VA to provide outpatient care, including outpatient diagnostic and consultative services to individual patients referred by a sharing partner (e.g., a community physician wanting to send patients to VA for laboratory work) provided the contract with the community sharing partner stipulates that the sharing partner will be responsible for directly paying VA the full contract amount for services rendered to non-veterans. No contracts will be executed which require VA to coordinate insurance benefits or to pursue third party

insurance billings and collections. In the event that a community provider refers a non- veteran for diagnostic or consultative services, no billing under the sharing authority to either the non-veteran or to the non-veteran's third party insurance carrier will be undertaken. An appropriate Release of Medical Information form must be signed by the patient before information from VA medical records is released to the referring sharing partner.

(4) Unless the sharing partner is a State veterans home, VA may provide supplies, drugs, and prosthetics only if the items are integral to the provision of medical services to be furnished by VA under a sharing agreement (e.g., flu shots, chemotherapy, emergency short-term prescriptions, but only as part of a services contract where VA is providing preventive, oncological, or medical treatment services).

(5) VA may sell the professional services of VA pharmacists and may provide mail-out pharmacy and pharmacy benefits management services to a sharing partner provided the sharing partner buys or provides the drugs and/or supplies. VA may not re-sell pharmaceuticals or supplies.

(6) VA may sell radio-pharmaceuticals produced by VA for use outside of a VA facility provided all necessary approvals from the Food and Drug Administration and the Nuclear Regulatory Commission are obtained for the manufacture of the items as a new drug.

(7) VA may enter into agreements with State Medicaid programs to provide services to State Medicaid beneficiaries. If a Medicaid beneficiary referred to VA for care is also a veteran, the beneficiary may request VA care as a veteran. If VA enrolls the veteran, or if the veteran is eligible for the VA care in question without being enrolled, VA would be prohibited from billing Medicaid for the care provided to the veteran. **NOTE:** *Any agreement to provide inpatient care to non-veterans requires the express approval of the Under Secretary for Health and of the Secretary of Veterans Affairs (see subpar. 3d.).*

(8) The sale of patient care services involves special consideration of medical records generated by VA.

(a) All contracts for the sale of direct patient care services by VA employees in VA-owned or leased space must specify that:

1. VA owns the records of care provided;
2. Individually identified and retrieved patient records are protected by the Privacy Act, 5 U.S.C. 552a;
3. Where VA is treating an individual for one of the medical conditions covered by 38 U.S.C. Section 7332, Section 7332 also applies to the treatment records; and
4. Where these statutes apply, the facility may release these records only as authorized under these statutes.

(b) Records generated by VA employees providing services to the general public at non-VA facilities are not VA records and are not covered by either the Privacy Act or 38 U.S.C. Section 7332.

(c) Records generated by VA employees providing services to the general public are not protected by 38 U.S.C. 5701, the VA benefits records confidentiality statute.

***NOTE:** Questions concerning ownership of, and application of Federal confidentiality laws to, records created by VA employees in the performance of a sharing agreement subject to this Directive should be referred to the Field Office of the General Counsel.*

(9) Service contracts may be executed for periods up to five years.

e. **Selling of Services.** VHA may sell support services and professional, managerial, and administrative services performed by VHA staff. These service contracts may be executed for periods up to five years.

(1) Duties of VA staff under terms of the contract may not include responsibility for personnel actions, such as hiring, firing, or disciplinary actions on behalf of the sharing partner, representing the sharing partner in public venues, or setting policy for the sharing partner.

(2) VHA may sell education services provided the educational program is part of veteran patient or staff continuing education. Examples include smoking cessation classes, Cardiopulmonary Resuscitation (CPR) certification training, nursing assistant training, seminars for Continuing Medical Education (CME) credit, and some support services certification internship programs. Appropriate reimbursement rates will be established and collected for these services. A sharing contract must be executed either with each individual receiving these education services, in which case the individual will be responsible for payment in advance to VA, or with a sponsoring organization which would assume responsibility for payment to VA.

(3) In all circumstances where there is a request for catering services for a meeting or other function on VHA property or for food service for employees or for visitors, Canteen Service shall have the right of first refusal. Only after Canteen Service has indicated that they are not interested or cannot provide the requested service, can a medical center's food and nutrition service enter into a sharing contract to provide a catering food service on VA grounds.

(4) Because VA police officers have law enforcement authority only on Department property, VA may only sell police and security services to sharing partners who are physically located on VA property. VA police and security units may perform security assessments and provide consultative and training services to any sharing partner at any location.

(5) VA may not sell agent cashier services. VA may not hold money for another party or pay out money on its behalf. This would create a fiduciary relationship and, except for very limited circumstances, such as for the joint acquisition of high-tech medical equipment with a sharing partner, VA is not authorized by law to perform such "banking" functions.

(6) All sharing agreements under 8153 and 8111 authorities for human immunodeficiency virus (HIV) testing service alone or as part of medical evaluations, clinical care or screening programs shall include as part of this service pre-test counseling and post-test counseling to be conducted by VA HIV test counselors or appropriately trained VA personnel. Elements of pre- and post-HIV test counseling are defined in the HIV test provisions of Circular 10-88-151, Section e (for pre-test counseling) and Section f (for post-test counseling) and Section g (for documentation requirements). If there are questions when considering the development of sharing agreements that may include HIV testing services, please consult with Director, VA AIDS Service (132), Dr. Lawrence Deyton at 202 273-8567.

f. **State Veterans Homes (SVH)**

(1) VA may not enter into a sharing agreement to manage a SVH.

(2) SVHs may be granted direct access to Federal Supply Schedule (FSS) contracts for services, equipment and supplies, including pharmaceuticals, after the SVH has executed a sharing contract under this authority to purchase use of space, use of equipment, or services from a VA facility. Once such a contract has been executed, the Office of Finance Sharing and Purchasing Office (175) in VHA Headquarters will arrange with the National Acquisition Center (NAC) for that SVH to be added to the list maintained by the NAC of SVH's authorized to buy from the FSS.

g. **Reimbursement Rates.** Reimbursement rates (i.e., prices) and procedures will be negotiated in the best interest of the Federal Government.

(1) VA facilities will consider local commercial market rates for similar services, as well as the full cost as defined by the Federal Accounting Standards Advisory Board for providing the service when negotiating reimbursement rates (see par. 5). Facilities are encouraged to maximize revenue generated from the sale of use of space or equipment and services under this authority. Prices may be established above full cost.

(2) Depending on the services(s) covered by the contract, per procedure pricing, capitated rates, hourly rates, Full-time Employee Equivalent (FTEE) rates, payment for specified deliverable (e.g., a report), or other reimbursement rate methodologies are considered appropriate for these contracts. **NOTE:** *Using rates established by the Health Care Financing Administration (HCFA) is encouraged.*

(3) In setting any reimbursement rates, VA must be sensitive to private sector perceptions that Federal funds are being used to subsidize operation costs, that VA pays no State, local, or Federal taxes, that VA is not borrowing money at interest to finance construction and new equipment purchases, and that VA is able to set an artificially low price for services.

(4) Less than full cost may be considered in setting a price for services only if the contract is necessary to maintain the level of quality or to keep a program in existence for veteran care. **NOTE:** *For example: less than full cost may be acceptable for the sale of a surgical service if there is insufficient veteran caseload to maintain an acceptable skill level of the surgical staff*

and additional caseload is needed for quality of care. In no instance will any contract be executed where the reimbursement rate is determined to be less than the local direct cost which is defined as the Decision Support System (DSS) fixed direct, variable labor, variable supply, and depreciation costs for the service under consideration. Local direct cost can also be considered as average total cost.

(5) The rationale and justification for all price determinations shall be fully explained and documented and maintained in the contract file and shall be sent with a copy of the executed contract to the Sharing and Purchasing Office (175).

(6) When VHA facilities choose to set reimbursement rates using a capitation methodology, they must carefully consider and include factors such as stop loss, reinsurance, or similar measures to ensure that appropriated dollars are not used to cover unanticipated operational losses resulting from capitated contracts.

(7) Pub. L. 104-262 contains a provision requiring Medicare to reimburse either VA or the sharing partner (as provided in the terms of the sharing contract) at established Medicare rates for Medicare covered services provided to Medicare beneficiaries who are not veterans eligible for VA medical care. **NOTE:** *Until additional guidance is issued in a future VHA Directive, no claims should be submitted by VA facilities to Medicare Fiscal Intermediaries for payment for services provided under sharing contracts. Accordingly, facilities should not agree to terms in proposed sharing agreements that would require VA to bill Medicare.*

h. **Proceeds.** All proceeds generated by health resources sharing contracts will be credited to the appropriate medical or research appropriation at the facility providing the service and will be immediately available for use by the facility. Any amount received as payment for services provided by VA in a prior fiscal year may be obligated during the fiscal year in which the payment is received. It may be to the medical center's advantage to include terms in the contract for VA to receive payments normally made in September on or after October 1.

i. **Regional Counsel Consultation.** In all cases where VA would be selling services, resources, or use of space or equipment to an entity which has an existing contract to sell or provide other services to VA, the designated enhanced sharing regional counsel staff attorney will be consulted early in the process of developing the contract, and certainly in advance of execution of the contract, regarding any possible conflict of interest. The designated enhanced sharing regional counsel staff attorney also will be consulted in all cases where VA is proposing to sell services, resources, or use of space to part-time or to full-time VA staff or to individuals who may have a personal or close financial relationship with VA staff. When VA sells to its employees, questions reasonably may be raised regarding the fairness of the selling process. For this reason, contracts for the sale of use of space or equipment, or services to individuals with any kind of employment relationship to VA are prohibited except for medical research purposes. When facilities decide to consider such agreements, prices must be set at the commercial market rate or at full cost, whichever is higher.

j. **Additional FTEE or Contract Staff.** Additional FTEE may be hired or VA may contract for staff to provide services to non-veterans as long as no statute or appropriation prohibits the

hiring and the activity falls within VA's mission. The use of term or temporary appointments is preferred over the hiring of permanent new staff in the event that contracts are not successful or if they are not renewed after the first year. However, any "new hires" must be approved by the VISN Director who must take into account impacts from reductions in staff relating to veterans care. Facilities may employ the services of veterans in the Compensated Work Therapy (CWT) program provided the CWT program fund is paid for the veterans' time. However, because CWT workers are not considered VA employees or VA contractors, CWT workers cannot have any access to patient records.

k. **Additional Equipment.** Additional equipment may be purchased through the already established processes. Existing procedures may be used to reprogram funds as needed.

l. **Commercial Loans.** VA facilities may not enter into commercial loans for any purpose. VHA may not make capital investments in either facility improvements or in the purchase of additional equipment to accommodate unknown future requirements solely for the purpose of selling services (i.e., a VA facility cannot create or establish a new service just to sell it).

m. **VA Response to Proposals and Bids.** VA may respond with proposals and bids to solicitations for services issued by any appropriate potential sharing partner.

n. **Marketing.** VISNs and medical centers are encouraged to develop a long-term marketing strategy. Marketing should make potential partners in their local communities aware of opportunities to buy services from VA and enhance the reputation of the VA health care system as a reliable business partner.

(1) VISNs and facilities are encouraged to consider opportunities with local businesses and governments that may not be involved in direct health care. The opportunities could include such services as pre-employment physicals to an industrial manufacturer; or nursing assistant training to a public housing authority as part of a welfare-to-work program.

(2) VA policy on paid media advertising is set forth in VA Manual MP-1, Part I, Chapter 4, subparagraph 4e. VHA facilities may purchase media advertising to sell VA health-care resources to non-VA health-care providers. VHA facilities must consult with and receive written or electronic approval from the Office of Public Affairs (OPA) Regional Office for all such advertisements

o. **Competitive Process.** Although there is no requirement for VA to follow a competitive process in selling the use of space, equipment, or services, facilities should consider doing so when appropriate.

p. Contracts for the sale of services shall not be signed without prior approval from the Rapid Response Team, VA Central Office.

4. ACTION

a. Medical centers and VISNs are strongly encouraged to use a concurrent team approach in selling health care resources. When an opportunity to sell a resource is under serious consideration, a business team shall be established, as appropriate, to coordinate the activity. The determination of the membership of the team shall be at the discretion of the facility or VISN; however, the following functions must be included:

(1) **Coordination of Facility-wide Activities.** An individual with sufficient knowledge of the facility's operations must be part of the team. This person will ensure that services to veterans will not be compromised, that the opportunity to sell health care resources is consistent with the overall mission of the facility, that politically sensitive issues have been considered, and that coordination with stakeholders has occurred.

(2) **Authority to Sell.** A person with authority to commit VA to a binding sales agreement will be included (see subpar. 4g.).

(3) **Financial Analysis.** A person with the ability to determine the financial feasibility of the opportunity will be a member of the team.

(4) **Legal Support.** The team shall seek legal advice from the Office of the General Counsel Washington, DC, or General Counsel field staff, from the beginning of the concept development through execution of the agreement.

(5) **Human Resources and Union Representatives.** In situations where selling a resource may affect employees (e.g., change in work site), a human resources representative will be part of the team. If any of the affected employees are bargaining unit members, the exclusive representative(s) will be included.

(6) **Program Officials.** When not prohibited by a conflict of interest or other bar, the individual responsible for the organizational element that will provide the resource will be included on the team. If that individual cannot participate, a designee will be included.

b. The team will meet to discuss the initial proposal and throughout the process. Meetings need not be face-to-face but may be conducted electronically or by conference calls.

c. Teams are required to make several critical determinations and to ensure that proper documentation exists to support each determination.

(1) **Determination of Capacity.** The team shall determine that sufficient capacity exists or can be generated to handle the work associated with the selling opportunity. This will include a determination that the proposed activity will not diminish existing levels of services to veterans and that the contract is necessary either to maintain an acceptable level or quality of care or to improve services to veterans. Any revenue generated from the contract will be used to benefit veterans. Decisions to sell resources should be based on sound business principles. The team must be able to document how VA benefits from the sale of the resource.

(2) **Determination of Costs.** Both local direct costs and full costs must be determined. There is no single costing methodology that will fit all circumstances. Good judgement must be exercised in choosing the methodology most appropriate to the resource in question. The methodology chosen for determining costs shall be documented and cost worksheets maintained in the contract file. For facilities that have fully implemented DSS, the DSS is a good source of cost information for clinical services. DDS may not serve as well for support or administrative services. The Cost Accounting and Medical Rates Division (0476C2) within VA Central Office is available to assist medical centers and VISNs with costing of contracts. This office also has the responsibility for conducting biennial user fee reviews.

(3) **Determination of a Fair Price.** In establishing a price for the resource, the team will take into account local direct costs, full costs, and local market prices for the same resource. Local market prices can be obtained through market surveys, third party and Medicare reimbursement rates, etc. Penalties for failure to perform or the cost of equipment replacement are examples of items that may or may not be appropriate to include in developing costs for a given proposal. In most instances, prices should be set comparable to prices in the commercial market. VA is not limited to recovering full cost in setting a price. The team must determine a price that is in the best interest of the Federal Government. If, and only if, the agreement is necessary to maintain an acceptable level or quality of care, it may be determined to be in the best interest of the Federal Government to establish a price that is below full cost. Otherwise, the price must be established at or above full cost. The team will document the rationale used in determining a price.

(4) **Determination of a Negotiating Range.** The team will develop a range of prices to be used in negotiations and in developing a negotiating strategy. The range may include considerations, such as volume discounts or a multi-tiered pricing structure, community needs, and effects on relationships with potential sharing partners. It may be necessary to identify a break-even point and establish a price floor below which VA will not negotiate, even if the end result is failure to reach agreement. In no instance will any contract be executed if revenues received do not recover local direct costs.

(5) **Determination of Marketing Approach.** Market research may be a critical step involving an assessment of the existence of potential partners, or an assessment of community needs or potential niche markets as examples. Any market research should be documented. When VA chooses to offer services on the open market, reasonable competition will occur. Potential buyers will be afforded the opportunity to offer bids for a VA resource. Notice may be made to the public through the CBD (Commerce Business Daily), VA web sites, or other media as appropriate. In other circumstances where a potential partner approaches VA, VA may decide to sell the resource directly to the soliciting buyer. Factors to be considered in making these decisions may include the relationship with the potential buyer, the market demand for the resource, the political sensitivity of the potential agreement, community needs, or other factors that may make the offer in the best interest of the Federal Government based on criteria other than price. VA may prepare and submit bids in response to solicitations announced and open to the public for response.

(6) **Determination of the Impact of the Proposed Sale on Accreditation.** The team must make an assessment of any potential impact of the proposed sale on accreditation, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), College of American Pathologists (CAP); facility licensing; licensing of employees; credentialing and privileging; risk management; etc.

(7) **Determination of Conflict of Interest.** The team, in consultation with General Counsel Washington, DC, or General Counsel field staff, must make an assessment of any potential conflicts of interest. A provision of the criminal code would prohibit an employee from participating in the selling process if the employee has any financial relationships with the non-VA parties involved. Such an individual may provide the team with workload or technical information, however, as determined by General Counsel VA Central Office or General Counsel field staff.

(8) **Determination of Impact.** The team must make a determination of impact of the proposed sale on other programs or elements in the facility.

(9) **Determination of Potential Liability.** The team must make a determination of the potential liability for failure to perform under the terms of the contract as well as other liability issues. Contingency plans should be developed to allow the facility to meet performance requirements under foreseeable circumstances or the contract should detail circumstances under which VA would not be expected to perform.

d. The team is responsible for making a written recommendation to the VISN Director or medical center Director, as appropriate, on whether or not to sell the resource in question, that recommendations to sell are in the interest of VA, and that the proposal meets the provisions of law, regulation and policy, taking the preceding factors into consideration. The VISN or medical center Director must certify the recommendation, as described in subparagraph 3a., as being necessary to maintain or improve services to veterans. A certification by the VISN Director or medical center Director is required, stating that the proposal is a sound business decision. VISN and medical center Directors may delegate the certification of the business decision to product line managers, or equivalent, for contracts with a total value of less than \$25,000.

e. Upon receipt of approval to sell a resource, a marketing plan will be developed, to include mechanisms for identifying buyers and a negotiating strategy. Strategy considerations include such factors as price, additional business opportunities, existing relationships, financial stability of potential purchasers, etc. The plan will be included as documentation in the contract file.

f. All contracts for the sale of health care resources must be in writing. No oral agreements are permitted. Terms to be included in the contract include: the ability to cancel the contract if the terms result in VA failing to meet requirements of law, particularly in regard to the diminution of services to veterans; time period covered by the contract; any mechanisms for adjusting prices; and liability assumed by VA for failure to perform. Other terms and conditions should address quantities, billing and payment terms, deadlines, quality issues, hours of operation, manpower commitments, ability to deliver services as required, and others as appropriate. With very few exceptions, all terms and conditions are negotiable.

g. In accordance with VA Handbook 7401.3, only the Deputy Assistant Secretary for Acquisition and Materiel Management (the Procurement Executive) is authorized to appoint or to terminate individuals as VA selling officials for health care resources sharing contracts. Only these individuals are vested with the authority to execute selling contracts on behalf of the Government. Senior level (unlimited) contracting officers are delegated this authority by virtue of their appointment through the Contracting Officer Certification Program (COCP), referenced at VA Acquisition Regulations (VAAR) 801.690. Other selling officials may be appointed by the Procurement Executive upon the request of medical center or VISN Directors. Requests for appointment or termination of selling officials may be made to the Procurement Executive through the Acquisition Training and Career Development Team (95) within VA Central Office. When recommending a candidate to be a selling official, the medical center or VISN Director shall follow procedures outlined in VA Handbook 7401.3.

h. Once the contract is executed, performance should be monitored closely. This involves the ongoing collection and maintenance of data. Facilities should monitor performance in the following areas and take appropriate action to correct problems promptly:

- (1) Are services to veterans being improved?
- (2) Are financial goals being met?
- (3) Are customers satisfied?
- (4) Are the terms of the contract being met?
- (5) Is the team involved and committed to success?
- (6) Is there ongoing risk assessment?

i. The Office of Finance SPO (175) is responsible for the preparation of an annual report to Congress on activities carried out under the health care resources sharing program. The annual report is prepared based on information furnished by each medical center at the end of each fiscal year. In response to an annual data call, each medical center shall report a description of the health care resource sold and the amount of money collected from the sale of that resource. Medical centers also are requested to furnish comments on the effectiveness of the program, the degree of cooperation from other sources (financial and otherwise), and any recommendations for the improvement or more effective administration of the program. This information is required for the Annual Report to the Congress per 38 U.S.C. Section 8153(g).

j. The following Financial Management System (FMS) Resource Codes are to be used for reporting revenue received in the medical center or VISN under this authority:

- (1) 8002 – Inpatient services.
- (2) 8006 – Out patient services.

(3) 8035 – Sharing all other. (**NOTE:** 8035 includes vacant land and space for roof top antennas).

4. REFERENCES

- a. Title 38 U. S. C. Sections 8151-8153.
- b. Public Law 104-262, Section 301.
- c. VAAR 801.602 and 801.690.
- d. VA Directive 7401.3.
- e. VA Handbook 7401.3.
- f. VA Directive 8500.
- g. VA Directive 4560.
- h. VA Handbook 4560.1.
- i. VA Handbook 8500.
- j. The Managerial Cost Accounting Implementation Guide.
- k. M-1, Part VII, Chapter 6.

5. DEFINITIONS

a. **Full Cost.** This term is defined by the Federal Accounting Standards Advisory Board (FASAB) in the Statement of Federal Financial Accounting Standards No. 4, Managerial Cost Accounting Concepts and Standards for the Federal Government, as "The sum of the costs of:

(1) Resources consumed by the segment that directly or indirectly contribute to the output, and

(2) Identifiable supporting services provided by other responsibility segments within the reporting entity, and by other entities."

NOTE: *The Managerial Cost Accounting Implementation Guide, issued jointly by the Government Chief Financial Officer (CFO) Council and Joint Financial Management Implementation Program (JFMIP) in February 1998, is a technical practice aid intended to assist Federal entities in implementing cost accounting. The Guide elaborates on the FASAB definition of full cost, by indicating that "Full cost is the sum of all costs required by a cost object including the costs of activities performed by other entities regardless of funding sources.*

It includes direct costs (costs specifically identified with the output) and indirect costs (costs used to produce multiple outputs). The direct and indirect costs can be funded, reimbursed, unfunded, or non-reimbursed."

b. **Local Direct Cost.** The DSS fixed direct, variable labor and variable supply are included in the local direct cost.

c. **Variable Overhead.** The portion of total overhead that varies directly with changes in volume. Examples are supplies and power.

d. **Fixed.** The portion of total overhead that remains constant over a given time period without regard to changes in the volume of activity. Examples are depreciation and rent.